

106TH CONGRESS
1ST SESSION

S. 1895

To amend the Social Security Act to preserve and improve the Medicare Program.

IN THE SENATE OF THE UNITED STATES

NOVEMBER 9, 1999

Mr. BREAU (for himself, Mr. FRIST, Mr. KERREY, and Mr. HAGEL) introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend the Social Security Act to preserve and improve the Medicare Program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare Preservation and Improvement Act of 1999”.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Findings and purposes.

TITLE I—ESTABLISHMENT OF MEDICARE COMPETITIVE
PREMIUM SYSTEM

Sec. 101. Establishment of Medicare competitive premium system.

“TITLE XXII—ESTABLISHMENT OF MEDICARE COMPETITIVE
PREMIUM SYSTEM

“Sec. 2200. Construction; references; definitions.

“PART A—MEDICARE PLANS; COMBINING PARTS A AND B

“Sec. 2201. Election of coverage through a Medicare plan and consolidated Medicare eligibility.

“Sec. 2202. Health benefits coverage.

“Sec. 2203. Continuation of beneficiary protections and other qualifications for Medicare plans.

“Sec. 2204. Exclusive payment methodology.

“PART B—COMPETITIVE PREMIUM SYSTEM

“Sec. 2221. Publication of geographic and risk adjusters.

“Sec. 2222. Submission of proposed Medicare plans.

“Sec. 2223. Board approval of proposed Medicare plans.

“Sec. 2224. Computation of core benefit premiums.

“Sec. 2225. Computation of national average premium.

“Sec. 2226. Payment of full amount of Medicare plan premiums.

“Sec. 2227. Computation of beneficiary obligation and drug discounts for beneficiaries enrolled in high option Medicare plans.

“Sec. 2228. Collection of beneficiary obligation.

“Sec. 2229. Relation to certain provisions.

“PART C—MEDICARE BOARD CHARTER

“Sec. 2241. Medicare Board.

“Sec. 2242. Duties of the Board.

“Sec. 2243. Powers of the Board.

“Sec. 2244. Board personnel matters.

“Sec. 2245. Reports; communications with Congress.

“Sec. 2246. Funding of the Board.

“PART D—UNIFIED MEDICARE TRUST FUND

“Sec. 2261. Unified Medicare Trust Fund.

“Sec. 2262. Programmatic insolvency and limitation on general revenue financing.

“PART E—HCFA DUTIES AND RESPONSIBILITIES

“Sec. 2281. Reorganization of HCFA.

“Sec. 2282. Establishment of HCFA-sponsored plans.

“Sec. 2283. Partnerships with private entities to offer HCFA-sponsored high option plans.

“Sec. 2284. HCFA business planning and administrative flexibility.”.

TITLE II—SPECIAL PROTECTIONS

SUBTITLE A—PROTECTION PACKAGE FOR CERTAIN AREAS

Sec. 201. Limitation on beneficiary obligations in certain areas.

Sec. 202. Guarantee of outpatient prescription drugs under HCFA-sponsored high option plans.

SUBTITLE B—LOW-INCOME MEDICARE BENEFICIARY PROTECTION PACKAGE

Sec. 251. Medicare plans for low-income Medicare beneficiaries.

“Sec. 2229. Medicare plans for low-income Medicare beneficiaries.”.

TITLE III—MEDICARE BENEFICIARY OUTREACH AND EDUCATION

Sec. 301. Medicare Consumer Coalitions.

TITLE IV—MISCELLANEOUS

Sec. 401. Conforming amendments.

Sec. 402. Medicare supplemental policies.

Sec. 403. Effective date.

1 **SEC. 2. FINDINGS AND PURPOSES.**

2 (a) FINDINGS.—

3 (1) Based on the deliberations of the National
 4 Bipartisan Commission on the Future of Medicare,
 5 the Medicare Program under title XVIII of the So-
 6 cial Security Act in its current form is unsustainable
 7 and is scheduled to become insolvent in 2015.

8 (2) Medicare’s spending, left unchecked, will
 9 continue to consume an increasing share of the Fed-
 10 eral budget, leaving little room for other priorities,
 11 such as defense, education, debt reduction, tax cuts,
 12 and domestic spending.

13 (3) Medicare’s current benefit package is out-
 14 dated in that it does not provide a prescription drug
 15 benefit and limits beneficiary access to new tech-
 16 nologies.

17 (4) Medicare only covers 53 percent of a bene-
 18 ficiary’s average health care costs and exposes bene-
 19 ficiaries to large out-of-pocket liabilities.

1 (5) The number of beneficiaries in the Medicare
2 Program is estimated to more than double by the
3 end of 2030, due to the influx of 77,000,000 baby
4 boomers beginning in 2010.

5 (6) Each year there are fewer workers paying
6 payroll taxes to fund current Medicare obligations,
7 evidenced by a decrease in the number of workers
8 per retiree from 4.5 in 1960 to 3.9 in 2000. This
9 number is expected to decline further to 2.8 in 2020.

10 (7) The Balanced Budget Act of 1997 and the
11 recent movement to restore some of its payment re-
12 ductions underscore the need to fundamentally re-
13 structure Medicare and reduce Government micro-
14 management of the Medicare Program.

15 (b) PURPOSES.—The purposes of this Act are—

16 (1) to promote high quality, comprehensive, in-
17 tegrated health care to meet the individual needs of
18 each Medicare beneficiary;

19 (2) to assist all Medicare beneficiaries, espe-
20 cially those with low incomes, in obtaining com-
21 prehensive benefits, including prescription drugs
22 through a health plan;

23 (3) to increase the flexibility of the Medicare
24 Program and provide Medicare beneficiaries timely

1 access to the latest advances in the practice of medi-
2 cine and delivery of care;

3 (4) to end the congressional micromanagement
4 over prices and delivery of benefits currently admin-
5 istered through approximately 130,000 pages of reg-
6 ulations established under the Medicare Program;
7 and

8 (5) to improve the existing Medicare Program
9 by adopting a stable, competitive system based on
10 the proven model of the Federal Employees Health
11 Benefits Plan, thereby providing Medicare bene-
12 ficiaries with better and broader health coverage and
13 a greater variety of reasonably priced health care op-
14 tions from which to choose.

15 **TITLE I—ESTABLISHMENT OF**
16 **MEDICARE COMPETITIVE**
17 **PREMIUM SYSTEM**

18 **SEC. 101. ESTABLISHMENT OF MEDICARE COMPETITIVE**
19 **PREMIUM SYSTEM.**

20 The Social Security Act is amended by adding at the
21 end the following:

1 “TITLE XXII—ESTABLISHMENT OF MEDICARE
2 COMPETITIVE PREMIUM SYSTEM

3 **“SEC. 2200. CONSTRUCTION; REFERENCES; DEFINITIONS.**

4 “(a) CONSTRUCTION OF TITLE.—The provisions of
5 this title shall be construed to modify and supersede the
6 provisions and operation of title XVIII to the extent such
7 provisions are inconsistent with the provisions of this title.

8 “(b) REFERENCES TO MEDICARE PROVISIONS.—Any
9 reference in any law or regulation to any provision of title
10 XVIII is deemed a reference to such provision as modified
11 through the operation of this title.

12 “(c) DEFINITIONS RELATING TO MEDICARE
13 PLANS.—As used in this title:

14 “(1) MEDICARE PLAN.—The term ‘Medicare
15 plan’ means a health benefits plan which the Medi-
16 care Board has approved under section 2223, and
17 includes each HCFA-sponsored plan.

18 “(2) STANDARD MEDICARE PLAN.—The term
19 ‘standard Medicare plan’ means a Medicare plan
20 that includes the core benefits under section
21 2202(a), but is not a high option Medicare plan.

22 “(3) HIGH OPTION MEDICARE PLAN.—The term
23 ‘high option Medicare plan’ means a Medicare plan
24 that, in addition to providing coverage for the core
25 benefits under section 2202(a), includes coverage for

1 outpatient prescription drugs under section 2202(b),
 2 and stop-loss coverage under section 2202(c).

3 “(4) HCFA-SPONSORED PLAN.—The term
 4 ‘HCFA-sponsored plan’ means a standard or high
 5 option Medicare plan established under section
 6 2282.

7 “(d) OTHER DEFINITIONS.—As used in this title:

8 “(1) CORE BENEFITS.—The term ‘core benefits’
 9 means the items and services described in section
 10 2202(a).

11 “(2) HCFA.—The term ‘HCFA’ means the
 12 Health Care Financing Administration, acting
 13 through the Administrator of such Administration.

14 “(3) MEDICARE BENEFICIARY.—The term
 15 ‘Medicare beneficiary’ means an individual entitled
 16 to benefits under title XVIII.

17 “(4) MEDICARE BOARD; BOARD.—The terms
 18 ‘Medicare Board’ and ‘Board’ mean the Board es-
 19 tablished under section 2241.

20 “(5) MEDICARE+CHOICE ORGANIZATION;
 21 MEDICARE+CHOICE PLAN.—The terms
 22 ‘Medicare+Choice organization’ and
 23 ‘Medicare+Choice plan’ have the meanings given
 24 such terms in subsections (a)(1) and (b)(1), respec-

3 “(6) MEDICARE TRUST FUND.—The term
4 ‘Medicare Trust Fund’ means the Trust Fund estab-
5 lished under section 2261.

6 “PART A—MEDICARE PLANS; COMBINING PARTS A AND B
7

8 “SEC. 2201. ELECTION OF COVERAGE THROUGH A MEDI-
9 CARE PLAN AND CONSOLIDATED MEDICARE
10 ELIGIBILITY.

“(a) CONTINUED ENTITLEMENT TO MEDICARE BENEFITS.—Beginning on January 1, 2003, Medicare beneficiaries shall continue to be entitled to receive benefits under title XVIII and shall receive such benefits through enrollment in a Medicare plan.

16 “(b) CONSOLIDATED MEDICARE ELIGIBILITY.—Be-
17 ginning January 1, 2003, an individual may receive bene-
18 fits under title XVIII only if such individual is entitled
19 under part A (or enrolled under such part) and enrolled
20 under part B of such title.

21 “(c) ENROLLMENT PROCESS.—

22 “(1) IN GENERAL.—The Medicare Board shall
23 establish a process for the enrollment of Medicare
24 beneficiaries under Medicare plans that is based, ex-
25 cept as the Board may provide, upon the process for

1 enrollment with Medicare+Choice plans under part
 2 C of title XVIII, including the provision of informa-
 3 tion and open enrollment and disenrollment opportu-
 4 nities.

5 “(2) TRANSITIONAL ENROLLMENT.—The Medi-
 6 care Board shall provide for such general enrollment
 7 period before January 1, 2003, as may be appro-
 8 priate to permit all individuals who are eligible to re-
 9 ceive benefits under part A or part B of title XVIII,
 10 but not both, to become eligible to receive benefits
 11 under such other part.

12 “(3) STUDY AND REPORT TO CONGRESS RE-
 13 GARDING TRANSITION PERIOD.—

14 “(A) STUDY.—The Medicare Board shall
 15 conduct a study on the need for—

16 “(i) establishing a period after Janu-
 17 ary 1, 2003, in which an individual, not-
 18 withstanding subsection (a), may receive
 19 benefits under part A of title XVIII with-
 20 out being enrolled under part B of such
 21 title or may receive benefits under part B
 22 of such title without being entitled under
 23 part A of such title; and

24 “(ii) adjusting the amount of the ben-
 25 eficiary obligation and drug discount com-

1 puted under section 2227 during the pe-
2 riod described in subparagraph (A).

3 “(B) REPORT.—Not later than January 1,
4 2002, the Medicare Board shall submit a report
5 to Congress on the study conducted under sub-
6 paragraph (A), together with any recommenda-
7 tions for legislation that the Board determines
8 to be appropriate as a result of such study.

9 “(4) STUDY AND REPORT TO CONGRESS RE-
10 GARDING SPECIAL RULES FOR END-STAGE RENAL
11 DISEASE.—

12 “(A) STUDY.—The Medicare Board shall
13 conduct a study on the need for a special rule
14 for individuals medically determined to have
15 end-stage renal disease, similar to the special
16 rule established under section 1851(a)(3)(B)
17 (relating to Medicare+Choice eligible individ-
18 uals).

19 “(B) REPORT.—Not later than January 1,
20 2002, the Medicare Board shall submit a report
21 to Congress on the study conducted under sub-
22 paragraph (A), together with any recommenda-
23 tions for legislation that the Board determines
24 to be appropriate as a result of such study.

1 “(5) STUDY AND REPORT ON ONE-TIME EN-
2 ROLLMENT.—

3 “(A) STUDY.—The Medicare Board shall
4 conduct a study on the need for rules relating
5 to a one-time enrollment of Medicare bene-
6 ficiaries in high option Medicare plans, includ-
7 ing HCFA-sponsored high option plans, similar
8 to the rules established under section 1882(s)
9 (relating to guaranteed issuance of Medicare
10 supplemental policies).

11 “(B) REPORT.—Not later than January 1,
12 2002, the Medicare Board shall submit a report
13 to Congress on the study conducted under sub-
14 paragraph (A), together with any recommenda-
15 tions for legislation that the Board determines
16 to be appropriate as a result of such study.

17 **“SEC. 2202. HEALTH BENEFITS COVERAGE.**

18 “(a) CORE BENEFITS.—Each Medicare plan shall
19 provide those items and services for which benefits are
20 available under parts A and B of title XVIII to Medicare
21 beneficiaries enrolled in the plan.

22 “(b) OUTPATIENT PRESCRIPTION DRUG BENEFIT.—

23 “(1) IN GENERAL.—Each high option Medicare
24 plan shall provide a benefit for outpatient prescrip-
25 tion drugs—

1 “(A) during 2003, that is actuarially
2 equivalent to an amount equal to \$800 on Jan-
3 uary 1, 2003; and

4 “(B) during a subsequent year, that is ac-
5 tuarily equivalent to the amount for each
6 Medicare beneficiary during the previous year,
7 adjusted for any increase in the reasonable cost
8 of outpatient prescription drugs during such
9 previous year.

10 “(2) COST CONTROL MECHANISMS.—In pro-
11 viding the outpatient prescription drug benefit under
12 paragraph (1), the entity offering each Medicare
13 plan (including a private entity with a contract
14 under section 2283) may use cost control mecha-
15 nisms that are customarily used in employer spon-
16 sored plans, including the use formularies, tiered co-
17 payments, selective contracting with providers of
18 outpatient prescription drugs, and mail order phar-
19 macies.

20 “(c) STOP-LOSS COVERAGE.—Each high option
21 Medicare plan shall provide a benefit for stop-loss cov-
22 erage that is designed to limit Medicare beneficiary cost-
23 sharing for core benefits during a year after the Medicare
24 beneficiary incurs out-of-pocket expenditures in excess
25 of—

1 “(1) during 2003, \$2,000 for the core benefits;
2 and

3 “(2) for any subsequent calendar year, the
4 amount for the previous year for the core benefits
5 increased by the average annual percentage increase
6 in expenditures per beneficiary under title XVIII
7 during the previous year, as estimated by the Medi-
8 care Board.

9 **“SEC. 2203. CONTINUATION OF BENEFICIARY PROTECTIONS**
10 **AND OTHER QUALIFICATIONS FOR MEDI-**
11 **CARE PLANS.**

12 “In order to be offered as a Medicare plan under this
13 part, except as otherwise provided in this title, the plan
14 and the entity offering the plan shall meet the require-
15 ments applicable to Medicare+Choice plans and
16 Medicare+Choice organizations under part C of title
17 XVIII, including—

18 “(1) the offering of Medicare benefits; and

19 “(2) protections for Medicare beneficiaries en-
20 rolled in the plans.

21 **“SEC. 2204. EXCLUSIVE PAYMENT METHODOLOGY.**

22 “(a) IN GENERAL.—Except as provided in this title,
23 for items and services furnished on or after January 1,
24 2003—

1 “(1) payment to an entity offering a Medicare
 2 plan in the amounts provided under this part shall
 3 be instead of any amounts that may be otherwise
 4 payable under title XVIII; and

5 “(2) only the entity offering the Medicare plan
 6 is eligible to receive payment for items and services
 7 under such title.

8 “(b) EXCEPTIONS.—Under rules established by the
 9 Medicare Board, the Board may provide for exceptions to
 10 subsection (a) under circumstances that are similar to the
 11 circumstances provided for under section 1851(i) (relating
 12 to effect of election of Medicare+Choice plan option).

13 “PART B—COMPETITIVE PREMIUM SYSTEM
 14 **“SEC. 2221. PUBLICATION OF GEOGRAPHIC AND RISK AD-**
 15 **JUSTERS.**

16 “(a) PUBLICATION.—Not later than April 15 of each
 17 year (beginning in 2002), the Medicare Board shall pub-
 18 lish the geographic and risk adjusters established under
 19 subsection (b) to be used in determining the amount of
 20 payment to Medicare plans computed under section 2226.

21 “(b) ESTABLISHMENT OF GEOGRAPHIC AND RISK
 22 ADJUSTERS.—

23 “(1) IN GENERAL.—Subject to paragraph (2),
 24 the Medicare Board shall establish an appropriate
 25 methodology for adjusting the amount of payment to

1 Medicare plans computed under section 2226 to take
2 into account, in a budget neutral manner, appro-
3 priate variation in costs for core benefits—

4 “(A) based on the provision of items and
5 services in different geographic areas; and

6 “(B) based on the differences in actuarial
7 risk of different enrollees being served.

8 “(2) CONSIDERATIONS.—In establishing an ap-
9 propriate methodology under this subsection, the
10 Medicare Board—

11 “(A)(i) subject to clause (ii), may take into
12 account the similar methodologies used under
13 section 1853 (relating to payments to
14 Medicare+Choice organizations); and

15 “(ii) shall limit the geographic adjustment
16 to variations based on input costs of providing
17 covered items and services in different areas;

18 “(B) may provide for the risk adjustment
19 to be effected through a pooling arrangement in
20 which unfavorable risks are shared among the
21 entities offering Medicare plans in an area,
22 rather than through risk adjustment of pay-
23 ment made with respect to Medicare bene-
24 ficiaries;

1 “(C) may establish other risk adjusters,
 2 such as those based on the length of time a
 3 Medicare beneficiary has been continuously en-
 4 rolled in a Medicare plan;

5 “(D) may phase-in geographic and risk ad-
 6 justers established under this section during the
 7 transition from the Medicare Program under
 8 title XVIII of the Social Security Act in effect
 9 on the date of enactment of this title as nec-
 10 essary to prevent large changes in the obliga-
 11 tion of Medicare beneficiaries during a year;
 12 and

13 “(E) shall consider the interrelationship of
 14 all adjustments to the amount paid to Medicare
 15 plans and obligations of Medicare beneficiaries
 16 under this section, to ensure that all Medicare
 17 plans have an incentive to provide efficient care.

18 **“SEC. 2222. SUBMISSION OF PROPOSED MEDICARE PLANS.**

19 “(a) IN GENERAL.—Each entity that intends to offer
 20 a Medicare plan in a year (beginning with 2003) shall sub-
 21 mit to the Medicare Board, at such time and in such man-
 22 ner as the Board may specify, such information as the
 23 Board may require to carry out title XVIII, including the
 24 information described in subsection (b) and taking into ac-

1 count the geographic and risk adjusters published under
2 section 2221.

3 “(b) INFORMATION DESCRIBED.—The information
4 described in this paragraph includes information on each
5 of the following:

6 “(1) BENEFITS.—A description of the benefits
7 under the plan.

8 “(2) PREMIUM BID.—The premium proposed to
9 be charged for enrollment under the plan.

10 “(3) SERVICE AREA.—The service area for the
11 plan.

12 **“SEC. 2223. BOARD APPROVAL OF PROPOSED MEDICARE**
13 **PLANS.**

14 “(a) APPROVAL OF MEDICARE PLANS BY MEDICARE
15 BOARD.—

16 “(1) IN GENERAL.—Subject to paragraph (2),
17 the Medicare Board shall approve Medicare plans—

18 “(A) in accordance with the requirements
19 established under subsection (b) and, in the
20 case of a high option Medicare plan, subsection
21 (c); and

22 “(B) subject to the terms and conditions
23 established under subsection (d).

24 “(2) HIGH OPTION MEDICARE PLAN RE-
25 QUIRED.—The Medicare Board may approve the of-

1 fering of a standard Medicare plan by an entity
 2 under this title in a service area only if the entity
 3 also offers a Medicare plan that has been approved
 4 as a high option Medicare plan in accordance with
 5 the requirements established under subsection (c) in
 6 that service area.

7 “(b) REQUIREMENTS FOR ALL MEDICARE PLANS.—
 8 The Medicare Board may approve a Medicare plan only
 9 if such plan meets the following requirements:

10 “(1) BENEFITS.—

11 “(A) IN GENERAL.—The Board may ap-
 12 prove a Medicare plan submitted under section
 13 2222 only if the benefits under such plan—

14 “(i) include the core benefits under
 15 section 2202(a); and

16 “(ii) are not designed in such a man-
 17 ner that the Board finds that it is likely to
 18 result in favorable selection of Medicare
 19 beneficiaries.

20 “(B) VARIATION IN COST-SHARING.—

21 “(i) IN GENERAL.—Except for the
 22 HCFA-sponsored plans established under
 23 section 2202, for purposes of approving a
 24 Medicare plan, the Medicare Board may
 25 permit reasonable variation in cost-sharing

1 so long as the actuarial equivalence of total
 2 cost-sharing for the core benefits is main-
 3 tained.

4 “(ii) RULE OF CONSTRUCTION.—
 5 Nothing in this subparagraph shall be con-
 6 strued as preventing a Medicare plan from
 7 providing, as an additional benefit, a lower
 8 level of cost-sharing from that otherwise
 9 described in title XVIII.

10 “(2) PREMIUM BID.—The Board may approve a
 11 premium bid submitted under section 2222 only if
 12 the Board finds that the premium rates are ade-
 13 quate in terms of actuarial soundness to assure the
 14 financial solvency of the entity offering the plan.

15 “(3) SERVICE AREA.—The Board may approve
 16 a service area submitted under section 2222 only if
 17 the Board finds that—

18 “(A) the use of such an area is consistent
 19 with the purposes of this title; and

20 “(B) the service area for the plan is not
 21 designed so as to discriminate based on the
 22 health status, economic status, or prior receipt
 23 of health care of Medicare beneficiaries.

24 “(c) SPECIAL REQUIREMENTS FOR HIGH OPTION
 25 MEDICARE PLANS.—The Medicare Board may approve a

1 Medicare plan as a high option Medicare plan only if such
 2 plan includes, in addition to the core benefits under sec-
 3 tion 2202(a), coverage for outpatient prescription drugs
 4 under section 2202(b), and stop-loss coverage under
 5 2202(c).

6 “(d) TERMS AND CONDITIONS.—

7 “(1) IN GENERAL.—Medicare plans approved
 8 under this section shall be subject to such additional
 9 terms and conditions as the Board may specify.

10 “(2) NEGOTIATION.—

11 “(A) IN GENERAL.—Subject to subpara-
 12 graph (B), for purposes of specifying the terms
 13 and conditions under paragraph (1), the Board
 14 may negotiate with any entity offering a Medi-
 15 care plan regarding the terms and conditions of
 16 such plan.

17 “(B) LIMITATION.—The Medicare Board
 18 may approve a Medicare plan only if the Board
 19 finds that the negotiated terms and conditions
 20 are consistent with the requirements of this
 21 title.

22 **“SEC. 2224. COMPUTATION OF CORE BENEFIT PREMIUMS.**

23 “(a) IN GENERAL.—For each year (beginning with
 24 2003), the Medicare Board shall compute a core benefit
 25 premium for each Medicare plan approved under section

1 2223 that reflects only the actuarial value of the core ben-
 2 efits offered under the Medicare plan.

3 “(b) DE MINIMIS BENEFITS INCLUDED.—For pur-
 4 poses of computing the core-benefit premium under sub-
 5 section (a), the Board may include de minimis benefits
 6 that are not core benefits.

7 **“SEC. 2225. COMPUTATION OF NATIONAL AVERAGE PRE-**
 8 **MIUM.**

9 “(a) COMPUTATION.—

10 “(1) IN GENERAL.—For each year (beginning
 11 with 2003) the Medicare Board shall compute a na-
 12 tional average premium equal to the average of the
 13 core benefit premium for each Medicare plan (as
 14 computed under section 2224).

15 “(2) WEIGHTED AVERAGE.—The national aver-
 16 age premium computed under paragraph (1) shall be
 17 a weighted average, with the weight for each plan
 18 being equal to the average number of beneficiaries
 19 enrolled under such plan in the previous year.

20 “(b) SPECIAL RULE FOR 2003.—For purposes of ap-
 21 plying subsection (a) in 2003, Medicare beneficiaries who
 22 obtained benefits—

23 “(1) under the original fee-for-service program
 24 under parts A and B of title XVIII as in effect on
 25 the date of enactment of this title are deemed to

1 have been enrolled in the HCFA-sponsored standard
 2 plan; and

3 “(2) through enrollment in a Medicare+Choice
 4 plan (or similar plan) are deemed to have been en-
 5 rolled in the Medicare plan the Board determines is
 6 most comparable to the Medicare+Choice plan (or
 7 similar plan) in which the individual was enrolled on
 8 such date.

9 **“SEC. 2226. PAYMENT OF FULL AMOUNT OF MEDICARE**
 10 **PLAN PREMIUMS.**

11 “(a) IN GENERAL.—Subject to subsection (b), for
 12 each year (beginning with 2003), the Board shall pay to
 13 each Medicare plan in which a Medicare beneficiary is en-
 14 rolled an amount equal to—

15 “(1) the full amount of the premium approved
 16 under section 2223(b)(2) on behalf of each Medicare
 17 beneficiary enrolled in such plan for the year, as ad-
 18 justed using the geographic and risk adjusters that
 19 apply to the core benefits published under section
 20 2221; minus

21 “(2) the amount of any fees (as computed
 22 under section 2246(b)).

23 “(b) PAYMENT TERMS.—Payment under this section
 24 to an entity offering a Medicare plan shall be made in
 25 a manner determined by the Medicare Board and based

1 upon the manner in which payments are under section
 2 1853(a) (relating to payments to Medicare+Choice orga-
 3 nizations).

4 **“SEC. 2227. COMPUTATION OF BENEFICIARY OBLIGATION**
 5 **AND DRUG DISCOUNTS FOR BENEFICIARIES**
 6 **ENROLLED IN HIGH OPTION MEDICARE**
 7 **PLANS.**

8 “(a) COMPUTATION OF BENEFICIARY OBLIGA-
 9 TION.—Subject to subsection (b), the annual beneficiary
 10 obligation for enrollment in a Medicare plan for a year
 11 shall be determined as follows:

12 “(1) MEDICARE PLAN PREMIUMS OF LESS
 13 THAN 85 PERCENT OF THE NATIONAL AVERAGE.—If
 14 the amount of the premium approved by the Board
 15 under section 2223 for the Medicare plan does not
 16 exceed 85 percent of the national average premium
 17 (as computed under section 2225) the obligation of
 18 the Medicare beneficiary shall be zero.

19 “(2) MEDICARE PLAN PREMIUMS BETWEEN 85
 20 AND 100 PERCENT OF THE NATIONAL AVERAGE.—If
 21 the amount of the premium approved by the Board
 22 under section 2223 for a Medicare plan exceeds 85
 23 percent of the national average premium, but does
 24 not exceed 100 percent of the national average pre-
 25 mium, the obligation of the Medicare beneficiary

1 shall be equal to 80 percent of the amount by which
 2 the premium for the plan exceeds 85 percent of the
 3 national average premium.

4 “(3) MEDICARE PLAN PREMIUMS EQUAL TO OR
 5 GREATER THAN THE NATIONAL AVERAGE.—If the
 6 amount of the premium approved by the Board
 7 under section 2223 for a Medicare plan equals or ex-
 8 ceeds 100 percent of the national average premium
 9 the obligation of the Medicare beneficiary shall be
 10 equal to the sum of—

11 “(A) 12 percent of the national average
 12 premium; and

13 “(B) the amount by which the premium
 14 approved by the Board under section 2223 for
 15 the Medicare plan exceeds the amount of the
 16 national average premium.

17 “(b) DISCOUNTS FOR BENEFICIARIES ENROLLED IN
 18 HIGH OPTION MEDICARE PLANS.—

19 “(1) IN GENERAL.—The beneficiary obligation
 20 determined under this section for any Medicare ben-
 21 eficiary enrolled in a high option Medicare plan shall
 22 be reduced by the discount determined under para-
 23 graph (2).

24 “(2) DETERMINATION OF DISCOUNT.—The dis-
 25 count determined under this paragraph is the

1 amount equal to the applicable percentage (as deter-
 2 mined under paragraph (3)) of the benefit amount
 3 for outpatient prescription drugs determined under
 4 section 2202(b) for the year.

5 “(3) APPLICABLE PERCENTAGE.—

6 “(A) INDIVIDUALS WITH INCOME THAT EX-
 7 CEEDS 150 PERCENT OF POVERTY.—In the case
 8 of a Medicare beneficiary whose income (as de-
 9 termined for purposes of section 1905(p) and
 10 without regard to paragraph (4)) exceeds 150
 11 percent of the official poverty line (referred to
 12 in paragraph (2)(A) of such section) applicable
 13 to a family of the size involved, the applicable
 14 percentage shall be 25 percent.

15 “(B) INDIVIDUALS WITH INCOME BE-
 16 TWEEN 135 AND 150 PERCENT OF POVERTY.—
 17 In the case of a Medicare beneficiary whose in-
 18 come (as so determined) exceeds 135 percent
 19 but does not exceed 150 percent of such poverty
 20 line, the applicable percentage shall be a per-
 21 cent, equal to 50 percent reduced (but not
 22 below 25 percent) by 1.67 percentage points for
 23 each percentage point by which such income ex-
 24 ceeds 135 percent of such poverty line.

25 “(4) TAX TREATMENT OF DISCOUNT.—

1 “(A) IN GENERAL.—For purposes of the
 2 Internal Revenue Code of 1986, the discount
 3 determined under paragraph (2) for a Medicare
 4 beneficiary for a year shall be included in the
 5 gross income of the beneficiary for the year.

6 “(B) STATEMENT OF TAXABLE AMOUNT.—
 7 Not later than January 31 of each year (begin-
 8 ning with 2004), the Medicare Board shall
 9 provide—

10 “(i) each Medicare beneficiary with a
 11 statement that describes the amount of the
 12 discount that is required to be included in
 13 the gross income of the beneficiary for the
 14 previous year pursuant to subparagraph
 15 (A); and

16 “(ii) the Secretary of the Treasury
 17 with the information described in clause
 18 (i).

19 “(5) PUBLICATION OF DISCOUNTED PRE-
 20 MIUMS.—For each year (beginning with 2003), the
 21 Medicare Board shall publish in the Board’s an-
 22 nouncement of the premiums for Medicare plans
 23 each year the amount of the beneficiary obligation
 24 after applying the discount determined under para-
 25 graph (2) for each high option Medicare plan.

1 **“SEC. 2228. COLLECTION OF BENEFICIARY OBLIGATION.**

2 “(a) COLLECTION OF AMOUNT IN SAME MANNER AS
 3 PART B PREMIUM.—The amount of the annual bene-
 4 ficiary obligation determined under section 2227 shall be
 5 paid to the Medicare Trust Fund in the same manner as
 6 monthly premiums under part B of title XVIII were pay-
 7 able to the credit of the Federal Supplementary Medical
 8 Insurance Trust Fund under section 1840 (relating to
 9 payment of premiums) as in effect as of the date of enact-
 10 ment of this title.

11 “(b) INFORMATION NECESSARY FOR COLLECTION.—

12 In order to carry out paragraph (1), the Medicare Board
 13 shall transmit to the Commissioner of Social Security—

14 “(1) at the beginning of each year, the name,
 15 social security account number, and annual bene-
 16 ficiary obligation owed by each individual enrolled in
 17 a Medicare plan for each month during the year;
 18 and

19 “(2) periodically throughout the year, informa-
 20 tion to update the information previously trans-
 21 mitted under this paragraph for the year.

22 **“SEC. 2229. RELATION TO CERTAIN PROVISIONS.**

23 “(a) RELATION TO CERTAIN PROVISIONS.—Begin-
 24 ning on January 1, 2003, the following provisions of law
 25 are modified as follows, in order to reflect the policies
 26 specified in this part:

1 “(1) CHANGE IN PAYMENT RULES.—Subject to
 2 subsection (b), in applying section 1853 (relating to
 3 payments to Medicare+Choice organizations), pay-
 4 ment rates established under section 2226 shall su-
 5 persede the annual Medicare+Choice capitation rate
 6 calculated under section 1853(c) (relating to calcula-
 7 tion of annual Medicare+Choice capitation rates).

8 “(2) PART B PREMIUM.—No separate premium
 9 is payable under section 1839 (relating to amount of
 10 premiums).

11 “(b) RELATION TO OTHER PROVISIONS.—The fact
 12 that a provision is not cited in this subsection does not
 13 indicate that the provision is not modified under this title
 14 in some manner consistent with section 2200(a).

15 “PART C—MEDICARE BOARD CHARTER

16 **“SEC. 2241. MEDICARE BOARD.**

17 “(a) ESTABLISHMENT.—There is established as an
 18 independent agency of the United States a Medicare
 19 Board (in this part referred to as the ‘Board’).

20 “(b) MEMBERSHIP.—

21 “(1) NUMBER AND APPOINTMENT.—The Board
 22 shall be composed of 7 members appointed by the
 23 President, by and with the advice and consent of the
 24 Senate.

1 “(2) DEADLINE FOR INITIAL APPOINTMENT.—

2 The initial members of the Board shall be nominated
3 for appointment by not later than 6 months after
4 the date of enactment of this title.

5 “(3) TERMS.—

6 “(A) IN GENERAL.—The terms of mem-
7 bers of the Board shall be for 7 years, except
8 that of the members first appointed—

9 “(i) 3 shall be appointed for terms of
10 3 years;

11 “(ii) 2 shall be appointed for terms of
12 5 years; and

13 “(iii) 2 shall be appointed for terms of
14 7 years.

15 “(B) VACANCIES.—Any member appointed
16 to fill a vacancy occurring before the expiration
17 of the term for which the member’s predecessor
18 was appointed shall be appointed only for the
19 remainder of that term. A member may serve
20 after the expiration of that member’s term until
21 a successor has taken office.

22 “(C) LIMITATION ON NUMBER OF
23 TERMS.—Any person appointed as a member of
24 the Board shall not be eligible for reappoint-
25 ment to the Board after having served 2 terms.

1 “(4) CHAIRPERSON AND OTHER OFFICERS.—

2 The Board shall elect a chairperson and such offi-
3 cers as the Board determines appropriate.

4 “(c) OPERATION OF THE BOARD.—

5 “(1) MEETINGS.—The Board shall meet at the
6 call of its chairperson or a majority of its members.

7 “(2) QUORUM.—A quorum shall consist of 4
8 members of the Board, except that the Board may
9 establish a lesser quorum to conduct a hearing
10 under section 2243(a).

11 **“SEC. 2242. DUTIES OF THE BOARD.**

12 “(a) ADMINISTRATION OF COMPETITIVE PREMIUM
13 SYSTEM.—Except as otherwise provided in this title and
14 effective with respect to benefits furnished on or after Jan-
15 uary 1, 2003, the Board shall—

16 “(1) coordinate determinations of beneficiary
17 eligibility and enrollment under title XVIII with the
18 Commissioner of Social Security;

19 “(2) enter into, and enforce, contracts with en-
20 tities for the offering of Medicare plans under part
21 A of this title, including contracting with the Divi-
22 sion of HCFA-Sponsored Plans of HCFA (as estab-
23 lished under section 2281(a)(1)) for the offering of
24 the HCFA-sponsored plans;

1 “(3) disseminate to Medicare beneficiaries in-
2 formation with respect to benefits, limitations on
3 payment, under Medicare plans, including a com-
4 parative analysis of Medicare plans and the quality
5 of such plans in the area in which the Medicare ben-
6 eficiary resides; and

7 “(4) establish a Medicare beneficiary education
8 program to provide timely, readable, accurate, and
9 understandable information to Medicare beneficiaries
10 regarding Medicare plan options.

11 “(b) RELATION TO HCFA-SPONSORED PLANS.—The
12 Board shall not be responsible for the establishment and
13 operation of HCFA-sponsored plans (provided for under
14 section 2282), but shall have oversight authority over such
15 plans in a similar manner to that provided with respect
16 to other Medicare plans.

17 “(c) TRANSITION PROVISIONS.—The Secretary and
18 the Board shall cooperate to establish an appropriate tran-
19 sition of responsibility for the administration of title
20 XVIII and other related laws, from the Secretary to the
21 Board as is appropriate to carry out the purposes of this
22 title and as is consistent with the responsibilities of the
23 Division of Health Programs of HCFA (established under
24 section 2281(a)(2)). Insofar as a responsibility is trans-
25 ferred to the Board under this subsection, any reference

1 to the Secretary in title XVIII or other provision of law
 2 with respect to such responsibility is deemed to be a ref-
 3 erence to the Board.

4 **“SEC. 2243. POWERS OF THE BOARD.**

5 “(a) IN GENERAL.—The Board may, for the purpose
 6 of carrying out its duties, promulgate regulations, hold
 7 hearings, sit and act at times and places, take testimony,
 8 and receive evidence as the Board considers appropriate.

9 “(b) CONTRACT AUTHORITY.—The Board may con-
 10 tract with, and compensate, government and private agen-
 11 cies or persons for items and services, without regard to
 12 section 3709 of the Revised Statutes (41 U.S.C. 5).

13 “(c) BOARD AUTHORITY TO PERMIT FLEXIBILITY IN
 14 REQUIREMENTS.—In promulgating regulations under
 15 subsection (a) to carry out the requirements of part C of
 16 title XVIII, the Board may modify the regulations pre-
 17 viously promulgated by the Secretary to carry out such
 18 requirements (other than those relating to benefits or ben-
 19 efiary protections) as may be appropriate to better meet
 20 the needs of Medicare beneficiaries and promote fair and
 21 open competition among Medicare plans.

22 “(d) OVERSEEING SOLVENCY OF HCFA-SPONSORED
 23 PLANS.—The Board shall monitor and oversee the finan-
 24 cial solvency of the HCFA-sponsored plans in a manner
 25 similar to the manner in which State insurance commis-

1 sioners monitor and oversee the solvency of health insur-
 2 ance issuers in the States. The Board shall include in its
 3 periodic reports to Congress an analysis of the solvency
 4 of such plans.

5 **“SEC. 2244. BOARD PERSONNEL MATTERS.**

6 “(a) MEMBERS.—

7 “(1) COMPENSATION.—Members of the Board
 8 shall devote their entire time to the business of the
 9 Board, and each member shall be compensated at a
 10 rate equal to the per diem equivalent of the rate pro-
 11 vided for level II of the Executive Schedule under
 12 section 5315 of title 5, United States Code.

13 “(2) TRAVEL EXPENSES.—The members of the
 14 Board shall be allowed travel expenses, including per
 15 diem in lieu of subsistence, at rates authorized for
 16 employees of agencies under subchapter I of chapter
 17 57 of title 5, United States Code, while away from
 18 their homes or regular places of business in the per-
 19 formance of service for the Board.

20 “(3) REMOVAL.—The President may remove a
 21 member of the Board only for neglect of duty or
 22 malfeasance in office.

23 “(b) STAFF AND SUPPORT SERVICES.—

1 “(1) EXECUTIVE DIRECTOR.—The chairperson
2 shall appoint an executive director of the Board who
3 shall be paid at a rate specified by the Board.

4 “(2) STAFF.—With the approval of the Board,
5 the executive director may appoint such personnel as
6 the executive director considers appropriate.

7 “(3) INAPPLICABILITY OF CIVIL SERVICE
8 LAWS.—The staff of the Board shall be appointed
9 without regard to the provisions of title 5, United
10 States Code, governing appointments in the competi-
11 tive service, and shall be paid without regard to the
12 provisions of chapter 51 and subchapter III of chap-
13 ter 53 of such title (relating to classification and
14 General Schedule pay rates).

15 “(4) EXPERTS AND CONSULTANTS.—With the
16 approval of the Board, the executive director may
17 procure temporary and intermittent services under
18 section 3109(b) of title 5, United States Code.

19 “(c) TRANSFER OF PERSONNEL, ASSETS, ETC.—For
20 purposes of the Board carrying out its duties, the Sec-
21 retary and the Board may provide for the transfer to the
22 Board of such civil service personnel employed by the De-
23 partment of Health and Human Services, and such re-
24 sources and assets of the Department used in carrying out
25 title XVIII, as the Board requires.

1 **“SEC. 2245. REPORTS; COMMUNICATIONS WITH CONGRESS.**

2 “(a) REPORT ON MEDICARE PROGRAM.—Not less
3 frequently than annually, the Board shall submit to Con-
4 gress such reports describing the Medicare Program under
5 title XVIII as the Board determines appropriate.

6 “(b) MAINTAINING INDEPENDENCE OF BOARD IN
7 COMMUNICATIONS WITH CONGRESS.—The Board may di-
8 rectly submit to Congress reports, legislative recommenda-
9 tions, testimony, or comments on legislation. No officer
10 or agency of the United States may require the Board to
11 submit to any officer or agency of the United States for
12 approval, comments, or review, prior to the submission to
13 Congress of such reports, recommendations, testimony, or
14 comments.

15 **“SEC. 2246. FUNDING OF THE BOARD.**

16 “(a) INITIAL YEARS.—There is authorized to be ap-
17 propriated to the Board for each of fiscal years 2000
18 through 2002, in appropriate part from the Federal Hos-
19 pital Insurance Trust Fund and from the Federal Supple-
20 mentary Medical Insurance Trust Fund, such sums as are
21 necessary for the Board to carry out its duties.

22 “(b) FEES.—For purposes of the Board carrying out
23 its duties for fiscal years beginning after fiscal year 2002,
24 the Board may levy on Medicare plans an assessment suf-
25 ficient to pay its estimated expenses and the salaries of
26 its members and employees for a fiscal year. Such assess-

1 ments shall be deposited into the Medicare Trust Fund
 2 (established under section 2221) and shall be available for
 3 such purpose without regard to amounts provided for in
 4 advance by appropriations Acts.

5 “PART D—UNIFIED MEDICARE TRUST FUND

6 “SEC. 2261. UNIFIED MEDICARE TRUST FUND.

7 “(a) ESTABLISHMENT.—Beginning on January 1,
 8 2003, there is created on the books of the Treasury of
 9 the United States a trust fund to be known as the Medi-
 10 care Trust Fund.

11 “(b) AMOUNTS IN MEDICARE TRUST FUND.—

12 “(1) IN GENERAL.—The Medicare Trust Fund
 13 shall consist of the following amounts:

14 “(A) Amounts deposited in, or appro-
 15 priated to, the Medicare Trust Fund as pro-
 16 vided in this title.

17 “(B) Any gifts and bequests made to the
 18 Medicare Trust Fund as provided in section
 19 201(i)(1).

20 “(2) APPROPRIATION OF HOSPITAL INSURANCE
 21 TAXES.—

22 “(A) IN GENERAL.—Beginning January 1,
 23 2003, and for each subsequent year, there is
 24 appropriated to the Medicare Trust Fund, out
 25 of moneys in the Treasury not otherwise appro-

1 appropriated, an amount equal to 100 percent of the
 2 taxes described in paragraphs (1) and (2) of
 3 section 1817(a).

4 “(B) TRANSFER.—The amounts appro-
 5 priated pursuant to subparagraph (A) shall be
 6 transferred from time to time from the general
 7 fund in the Treasury to the Medicare Trust
 8 Fund. The amount to be transferred under this
 9 paragraph shall be determined on the basis of
 10 estimates by the Secretary of the Treasury of
 11 the taxes, described in such paragraph, paid to
 12 or deposited into the Treasury. The Secretary
 13 of the Treasury shall make adjustments in
 14 amounts subsequently transferred to the extent
 15 that prior estimates were in excess of, or were
 16 less than, such taxes.

17 “(3) GENERAL REVENUE CONTRIBUTION.—Be-
 18 ginning January 1, 2003, and for each subsequent
 19 year, there is appropriated to the Medicare Trust
 20 Fund, out of moneys in the Treasury not otherwise
 21 appropriated, from time to time, subject to the limi-
 22 tation described in section 2262(c), an amount equal
 23 to the amount by which the aggregate expenditures
 24 under this title (including payments made to Medi-
 25 care plans under section 2226) exceed the sum of—

1 “(A) the amount appropriated under para-
2 graph (2) for the period involved;

3 “(B) the beneficiary obligations collected
4 under section 2227 for such period; and

5 “(C) the fees collected under section 2246
6 for such period.

7 “(4) TRANSFER OF BALANCES IN HI AND SMI
8 TRUST FUNDS.—On January 1, 2003, the Secretary
9 of the Treasury shall transfer to the Medicare Trust
10 Fund any balances in the Federal Hospital Insur-
11 ance Trust Fund or the Federal Supplementary
12 Medical Insurance Trust Fund.

13 “(5) APPLICATION TO OBLIGATIONS OF, AND
14 AMOUNTS OWED TO, THE PART A AND B TRUST
15 FUNDS.—

16 “(A) CERTIFICATION.—Beginning January
17 1, 2003, the Director of the Division of HCFA-
18 Sponsored Plans of HCFA shall periodically
19 certify to the Board of Trustees of the Medicare
20 Trust Fund any amounts that would otherwise
21 be—

22 “(i) payable from the Federal Hos-
23 pital Insurance Trust Fund or the Federal
24 Supplementary Medical Insurance Trust

1 Fund for items and services provided prior
2 to such date; or

3 “(ii) due to such Trust Funds for
4 items and services provided prior to such
5 date.

6 “(B) TRANSFERS AND DEPOSITS.—

7 “(i) TRANSFERS.—If the Director of
8 the Division of HCFA-Sponsored Plans of
9 HCFA certifies an amount pursuant to
10 subparagraph (A)(i), the Board of Trust-
11 ees of the Medicare Trust Fund shall
12 transfer to the Director of the Division of
13 HCFA-Sponsored Plans of HCFA from
14 such Trust Fund an amount equal to the
15 amount certified.

16 “(ii) DEPOSITS.—If the Director of
17 the Division of HCFA-Sponsored Plans of
18 HCFA certifies an amount pursuant to
19 subparagraph (A)(ii), the Director of the
20 Division of HCFA-Sponsored Plans shall
21 deposit in the Medicare Trust Fund an
22 amount equal to the amount certified.

23 “(c) APPLICATION OF HI TRUST FUND PROVI-
24 SIONS.—Subject to other provisions of this title, the provi-
25 sions of subsections (b) through (k) of section 1817 shall

1 apply to title XVIII and the Medicare Trust Fund in the
 2 same manner as they apply to part A of title XVIII and
 3 the Federal Hospital Insurance Trust Fund, respectively.

4 “(d) CONFORMING PROVISIONS.—Beginning on Jan-
 5 uary 1, 2003—

6 “(1) no additional amounts are authorized to be
 7 appropriated under section 1844(a); and

8 “(2) no amounts shall be deposited in, or ap-
 9 propriated to, the Federal Hospital Insurance Trust
 10 Fund or the Federal Supplementary Medical Insur-
 11 ance Trust Fund.

12 “(e) CONFORMING REFERENCES.—Beginning on
 13 January 1, 2003, any reference in law or regulation (in
 14 effect before such date) to the Federal Hospital Insurance
 15 Trust Fund or the Federal Supplementary Medical Insur-
 16 ance Trust Fund is deemed a reference to the Medicare
 17 Trust Fund.

18 **“SEC. 2262. PROGRAMMATIC INSOLVENCY AND LIMITATION**
 19 **ON GENERAL REVENUE FINANCING.**

20 “(a) ANNUAL DETERMINATIONS.—In addition to any
 21 other duties, the Board of Trustees of the Medicare Trust
 22 Fund (in this section referred to as the ‘Board of Trust-
 23 ees’) shall determine and report to Congress as part of
 24 its annual report each year the following:

1 “(1) The percentage of total expenditures from
2 the Medicare Trust Fund that is financed by the
3 general revenue contributions described in section
4 2261(b)(3).

5 “(2) The first fiscal year (if any) that the Medi-
6 care Trust Fund is projected to become program-
7 matically insolvent (as defined in subsection (b)).

8 “(3) After taking into account the limitation
9 described in subsection (c), the first fiscal year (if
10 any) in which the amounts in the Medicare Trust
11 Fund will be insufficient to pay for the total ex-
12 penses incurred under title XVIII (as revised by this
13 title).

14 “(b) PROGRAMMATIC INSOLVENCY DEFINED.—

15 “(1) IN GENERAL.—For purposes of this part,
16 the Medicare Trust Fund shall be deemed to be
17 ‘programmatically insolvent’ for a fiscal year if the
18 amount appropriated to the Medicare Trust Fund
19 under section 2261(b)(3) would, but for subsection
20 (c), exceed 40 percent of the amount described in
21 paragraph (2).

22 “(2) NET EXPENDITURES ON BASIC BENE-
23 FITS.—The amount described in this paragraph is,
24 as estimated by the Board of Trustees in consulta-
25 tion with the Medicare Board and the Secretary of

1 the Treasury, the total expenditures from the Medi-
 2 care Trust Fund in the fiscal year involved, reduced
 3 by an amount equal to the administrative expenses
 4 of the Medicare Board for that fiscal year.

5 “(c) LIMITATION ON GENERAL REVENUE FINANC-
 6 ING.—The amount of the appropriation provided in sec-
 7 tion 2261(b)(3) in a fiscal year may not exceed 40 percent
 8 of the amount described in subsection (b)(2).

9 “PART E—HCFA DUTIES AND RESPONSIBILITIES

10 **“SEC. 2281. REORGANIZATION OF HCFA.**

11 “(a) ESTABLISHMENT OF DIVISIONS.—

12 “(1) DIVISION OF HCFA-SPONSORED PLANS.—
 13 There is established within HCFA the Division of
 14 HCFA-Sponsored Plans.

15 “(2) DIVISION OF HEALTH PROGRAMS.—There
 16 is established within HCFA the Division of Health
 17 Programs.

18 “(b) ADMINISTRATION.—

19 “(1) IN GENERAL.—Each Division established
 20 under subsection (a) shall be administered by a Di-
 21 rector appointed by the President with the advice
 22 and consent of the Senate. Level V of the Executive
 23 Schedule Pay Rates shall apply to each Director.

24 “(2) APPOINTMENT.—The President shall
 25 nominate a Director for each Division established

1 under subsection (a) by not later than 6 months
 2 after the date of enactment of this Act.

3 “(c) TRANSFER OF FUNCTIONS.—

4 “(1) DIVISION OF HCFA-SPONSORED
 5 PLANS.—There are transferred to the Division of
 6 HCFA-Sponsored Plans all functions relating to
 7 health care benefits that are made available under
 8 title XVIII through the original fee-for-service pro-
 9 gram (referred to in section 1851(a)(1)(A)) which
 10 HCFA exercised on the day before the date of enact-
 11 ment of this title (including all related functions of
 12 any officer or employee of HCFA).

13 “(2) DIVISION OF HEALTH PROGRAMS.—There
 14 are transferred to the Division of Health Programs
 15 all functions which HCFA exercised on the day be-
 16 fore the date of enactment of this title which are not
 17 transferred under paragraph (1) to the Division of
 18 HCFA-Sponsored Plans, including functions relating
 19 to the following:

20 “(A) The administration of the Medicaid
 21 Program under title XIX.

22 “(B) The administration of the State chil-
 23 dren’s health insurance program under title
 24 XXI.

1 “(C) Federal support of graduate medical
2 education.

3 “(D) Federal support of hospitals that
4 serve a significantly disproportionate number of
5 patients who have low income.

6 “(3) DETERMINATION OF CERTAIN FUNC-
7 TIONS.—If necessary, the Office of Management and
8 Budget shall make any determination of the func-
9 tions that are transferred under paragraphs (1) and
10 (2).

11 “(4) DEFINITION OF FUNCTION.—In this sec-
12 tion, the term ‘function’ means any duty, obligation,
13 power, authority, responsibility, right, privilege, ac-
14 tivity, or program.

15 “(5) OFFICE.—The term ‘office’ includes any
16 office, administration, agency, institute, unit, organi-
17 zational entity, or component thereof.

18 “(d) PERSONNEL.—

19 “(1) APPOINTMENTS.—Each Director ap-
20 pointed in accordance with subsection (b) may ap-
21 point and fix the compensation of such officers and
22 employees, including investigators, attorneys, and
23 administrative law judges, as may be necessary to
24 carry out the respective functions transferred under
25 subsection (c). Except as otherwise provided by law,

1 such officers and employees shall be appointed in ac-
2 cordance with the civil service laws and their com-
3 pensation fixed in accordance with title 5, United
4 States Code.

5 “(2) EXPERTS AND CONSULTANTS.—Each such
6 Director may—

7 “(A) obtain the services of experts and
8 consultants in accordance with section 3109 of
9 title 5, United States Code, and compensate
10 such experts and consultants for each day (in-
11 cluding travel time) at rates not in excess of the
12 rate of pay for level IV of the Executive Sched-
13 ule under section 5315 of such title; and

14 “(B) pay experts and consultants who are
15 serving away from their homes or regular place
16 of business travel expenses and per diem in lieu
17 of subsistence at rates authorized by sections
18 5702 and 5703 of such title for persons in Gov-
19 ernment service employed intermittently.

20 “(e) DELEGATION AND ASSIGNMENT.—Except where
21 otherwise expressly prohibited by law or otherwise pro-
22 vided by this section, each Director appointed in accord-
23 ance with subsection (b) may delegate any of the functions
24 transferred to the Director under subsection (c) and any
25 function transferred or granted to such Director after the

1 effective date of this title to such officers and employees
2 of the Division headed by such Director as the Director
3 may designate, and may authorize successive redelegations
4 of such functions as may be necessary or appropriate. No
5 delegation of functions by the Director of the Division of
6 HCFA-Sponsored Plans or the Division of Health Pro-
7 grams under this paragraph or under any other provision
8 of law shall relieve such Director of responsibility for the
9 administration of such functions.

10 “(f) REORGANIZATION.—Each Director appointed in
11 accordance with subsection (b) may allocate or reallocate
12 any function transferred under subsection (c) among the
13 officers of the Division headed by the Director, and to es-
14 tablish, consolidate, alter, or discontinue such organiza-
15 tional entities in the Division as may be necessary or ap-
16 propriate.

17 “(g) RULES.—Each Director appointed in accordance
18 with subsection (b) may prescribe, in accordance with the
19 provisions of chapters 5 and 6 of title 5, United States
20 Code, such rules and regulations as such Director deter-
21 mines are necessary or appropriate to administer and
22 manage the functions of the Division headed by the Direc-
23 tor.

24 “(h) TRANSFER AND ALLOCATIONS OF APPROPRIA-
25 TIONS AND PERSONNEL.—Except as otherwise provided

1 in this section, the personnel employed in connection with,
2 and the assets, liabilities, contracts, property, records, and
3 unexpended balances of appropriations, authorizations, al-
4 locations, and other funds employed, used, held, arising
5 from, available to, or to be made available in connection
6 with the functions transferred under subsection (c), sub-
7 ject to section 1531 of title 31, United States Code, shall
8 be transferred to the Division of HCFA-Sponsored Plans
9 or the Division of Health Programs, as appropriate. Unex-
10 pended funds transferred pursuant to this subsection shall
11 be used only for the purposes for which the funds were
12 originally authorized and appropriated.

13 “(i) INCIDENTAL TRANSFERS.—The Director of the
14 Office of Management and Budget, at such time or times
15 as the Director shall provide, is authorized to make such
16 determinations as may be necessary with regard to the
17 functions transferred by subsection (c), and to make such
18 additional incidental dispositions of personnel, assets, li-
19 abilities, grants, contracts, property, records, and unex-
20 pended balances of appropriations, authorizations, alloca-
21 tions, and other funds held, used, arising from, available
22 to, or to be made available in connection with such func-
23 tions, as may be necessary to carry out the provisions of
24 this section. The Director of the Office of Management
25 and Budget shall provide for the termination of the affairs

1 of all entities terminated by this section and for such fur-
 2 ther measures and dispositions as may be necessary to ef-
 3 fectuate the purposes of this section.

4 “(j) EFFECT ON PERSONNEL.—

5 “(1) IN GENERAL.—Except as otherwise pro-
 6 vided by this section, the transfer pursuant to this
 7 section of full-time personnel (except special Govern-
 8 ment employees) and part-time personnel holding
 9 permanent positions shall not cause any such per-
 10 sonnel to be separated or reduced in grade or com-
 11 pensation for 1 year after the date of transfer of
 12 such personnel under this section.

13 “(2) EXECUTIVE SCHEDULE POSITIONS.—Ex-
 14 cept as otherwise provided in this section, any per-
 15 son who, on the day preceding the effective date of
 16 this title, held a position compensated in accordance
 17 with the Executive Schedule prescribed in chapter
 18 53 of title 5, United States Code, and who, without
 19 a break in service, is appointed in the Division of
 20 HCFA-Sponsored Plans or the Division of Health
 21 Programs to a position having duties comparable to
 22 the duties performed immediately preceding such ap-
 23 pointment shall continue to be compensated in such
 24 new position at not less than the rate provided for

1 such previous position, for the duration of the serv-
 2 ice of such person in such new position.

3 “(k) SAVINGS PROVISIONS.—

4 “(1) CONTINUING EFFECT OF LEGAL DOCU-
 5 MENTS.—All orders, determinations, rules, regula-
 6 tions, permits, agreements, grants, contracts, certifi-
 7 cates, licenses, registrations, privileges, and other
 8 administrative actions—

9 “(A) which have been issued, made, grant-
 10 ed, or allowed to become effective by the Presi-
 11 dent, any Federal agency or official thereof, or
 12 by a court of competent jurisdiction, in the per-
 13 formance of functions which are transferred
 14 under subsection (c); and

15 “(B) which are in effect at the time this
 16 title takes effect, or were final before the effec-
 17 tive date of this title and are to become effec-
 18 tive on or after the effective date of this title,
 19 shall continue in effect according to their terms until
 20 modified, terminated, superseded, set aside, or re-
 21 voked in accordance with law by the President, the
 22 Director of the Division of HCFA-Sponsored Plans
 23 or the Director of the Division of Health Programs
 24 (as appropriate) or other authorized official, a court
 25 of competent jurisdiction, or by operation of law.

1 “(2) PROCEEDINGS NOT AFFECTED.—The pro-
2 visions of this section shall not affect any pro-
3 ceedings, including notices of proposed rulemaking,
4 or any application for any license, permit, certificate,
5 or financial assistance pending before HCFA at the
6 time this title takes effect, with respect to functions
7 transferred by subsection (c), and such proceedings
8 and applications shall be continued. Orders shall be
9 issued in such proceedings, appeals shall be taken
10 therefrom, and payments shall be made pursuant to
11 such orders, as if this section had not been enacted,
12 and orders issued in any such proceedings shall con-
13 tinue in effect until modified, terminated, super-
14 seded, or revoked by a duly authorized official, by a
15 court of competent jurisdiction, or by operation of
16 law. Nothing in this paragraph shall be deemed to
17 prohibit the discontinuance or modification of any
18 such proceeding under the same terms and condi-
19 tions and to the same extent that such proceeding
20 could have been discontinued or modified if this sec-
21 tion had not been enacted.

22 “(3) SUITS NOT AFFECTED.—The provisions of
23 this section shall not affect suits commenced before
24 the effective date of this title, and in all such suits,
25 proceedings shall be had, appeals taken, and judg-

1 ments rendered in the same manner and with the
2 same effect as if this section had not been enacted.

3 “(4) NONABATEMENT OF ACTIONS.—No suit,
4 action, or other proceeding commenced by or against
5 HCFA or by or against any individual in the official
6 capacity of such individual as an officer of HCFA,
7 shall abate by reason of enactment of this section.

8 “(5) ADMINISTRATIVE ACTIONS RELATING TO
9 PROMULGATION OF REGULATIONS.—Any administra-
10 tive action relating to the preparation or promulga-
11 tion of a regulation by HCFA relating to a function
12 transferred under this section may be continued by
13 the Division of HCFA-Sponsored Plans or the Divi-
14 sion of Health Programs (as appropriate) with the
15 same effect as if this section had not been enacted.

16 “(l) SEPARABILITY.—If a provision of this section or
17 its application to any person or circumstance is held in-
18 valid, neither the remainder of this section nor the applica-
19 tion of the provision to other persons or circumstances
20 shall be affected.

21 “(m) TRANSITION.—Each Director appointed in ac-
22 cordance with subsection (b) may utilize—

23 “(1) the services of such officers, employees,
24 and other personnel of the Department of Health
25 and Human Services with respect to functions trans-

1 ferred to the Division of HCFA-Sponsored Plans or
 2 the Division of Health Programs under subsection
 3 (c); and

4 “(2) funds appropriated to such functions for
 5 such period of time as may reasonably be needed to
 6 facilitate the orderly implementation of this section.

7 “(n) REFERENCES.—Reference in any other Federal
 8 law, Executive order, rule, regulation, or delegation of au-
 9 thority, or any document of or relating to HCFA with re-
 10 gard to functions transferred under subsection (c), shall
 11 be deemed to refer to the Division of HCFA-Sponsored
 12 Plans, the Director of the Division of HCFA-Sponsored
 13 Plans, the Division of Health Programs, or the Director
 14 of the Division of Health Programs, as appropriate.

15 **“SEC. 2282. ESTABLISHMENT OF HCFA-SPONSORED PLANS.**

16 “(a) ESTABLISHMENT.—

17 “(1) IN GENERAL.—Beginning on January 1,
 18 2003, the Director of the Division of HCFA-Spon-
 19 sored Plans of HCFA (in this section referred to as
 20 the “Director”) shall offer the Medicare plans de-
 21 scribed in paragraph (2).

22 “(2) HCFA-SPONSORED PLANS.—

23 “(A) HCFA-SPONSORED STANDARD
 24 PLANS.—The Director shall offer 1 standard
 25 Medicare plan throughout the United States,

1 which shall include only the core benefits under
 2 section 2202(a).

3 “(B) HCFA-SPONSORED HIGH OPTION
 4 PLANS.—The Director shall offer at least 1
 5 high option Medicare plan in each area within
 6 the United States, which shall include only—

7 “(i) the core benefits under section
 8 2202(a);

9 “(ii) the outpatient prescription drug
 10 benefit under section 2202(b), which shall
 11 be provided in accordance with section
 12 2283; and

13 “(iii) stop-loss coverage under section
 14 2202(c).

15 “(3) APPROVAL OF HCFA-SPONSORED PLANS.—

16 “(A) IN GENERAL.—Except as otherwise
 17 provided in this title, the HCFA-sponsored
 18 plans shall be subject to the provisions of this
 19 title in the same manner as other Medicare
 20 plans, including the requirement that the Direc-
 21 tor submit information regarding each HCFA-
 22 sponsored plan to be offered pursuant to section
 23 2222 and the required Board approval of such
 24 plans pursuant to section 2223.

1 “(B) PREMIUM BID APPROVAL.—The pre-
 2 miums submitted under section 2222 for the
 3 HCFA-sponsored standard plan and each
 4 HCFA-sponsored high option plan shall be com-
 5 puted separately to ensure that the HCFA-
 6 sponsored standard plan and each HCFA-spon-
 7 sored high option plan is separately self-sus-
 8 taining, without cross subsidies between the
 9 plans.

10 “(b) FINANCIAL PROVISIONS.—

11 “(1) ASSUMPTION OF FINANCIAL RISK.—Except
 12 as provided in section 2283(c), the Division of
 13 HCFA-Sponsored Plans of HCFA shall bear full fi-
 14 nancial risk for the provision of services under the
 15 HCFA-sponsored plans in the same manner as a
 16 Medicare+Choice organization bears full financial
 17 risk for a Medicare+Choice plan that it offers under
 18 section 1855(b). In assuming such risk, the Division
 19 of HCFA-Sponsored Plans may ensure continued
 20 solveny of such plans through improvements in the
 21 efficiency and economy of the HCFA-sponsored
 22 plans.

23 “(2) FUNDING.—

24 “(A) IN GENERAL.—In order to provide
 25 for capital for the HCFA-sponsored plans prior

1 to January 1, 2003, the Board of Trustees of
 2 the Federal Hospital Insurance Trust Fund, at
 3 the direction of the Medicare Board, shall
 4 transfer from such Trust Fund to the Division
 5 of HCFA-Sponsored Plans of HCFA such
 6 amounts as may be necessary to provide for the
 7 following:

8 “(i) INITIAL CAPITALIZATION AC-
 9 COUNT.—Amounts that may be required
 10 for the initial organization of HCFA-spon-
 11 sored plans.

12 “(ii) WORKING CAPITAL (CASH FLOW)
 13 ACCOUNT.—Amounts that may be required
 14 as working capital in order to assure time-
 15 ly payment of obligations by such plans.

16 “(iii) CONTINGENCY RESERVE.—Rea-
 17 sonable amounts that should be held in re-
 18 serve to cover actuarial contingencies.

19 “(B) ESTABLISHMENT OF AMOUNTS.—The
 20 amounts described in subparagraph (A) shall be
 21 established by the Director and are subject to
 22 review and approval by the Medicare Board.

23 “(C) AMOUNT OF CONTINGENCY RE-
 24 SERVE.—In reviewing and approving the
 25 amount of the contingency reserve described in

1 subparagraph (A)(iii), the Medicare Board shall
 2 consider similar amounts required for health in-
 3 surance coverage offered under State law, tak-
 4 ing into account differences between the dif-
 5 ferent actuarial risks and demographic charac-
 6 teristics of the populations being served.

7 “(3) SEPARATE ACCOUNT.—

8 “(A) IN GENERAL.—Subject to subpara-
 9 graph (B), the Division of HCFA-Sponsored
 10 Plans of HCFA shall maintain the amounts
 11 transferred under this paragraph in a separate
 12 account, which shall only be available for ex-
 13 penses associated with the establishment and
 14 operation of the HCFA-sponsored plans.

15 “(B) LIMITATION.—Except as provided in
 16 section 2281(h) (relating to transfer of appro-
 17 priations in connection with functions trans-
 18 ferred to the Division of HCFA-Sponsored
 19 Plans under such section), and section
 20 2261(b)(4) (relating to obligations of the part
 21 A and part B trust funds), no funds from the
 22 Medicare Trust Fund may be appropriated to
 23 the Division of HCFA-Sponsored Plans of
 24 HCFA.

1 **“SEC. 2283. PARTNERSHIPS WITH PRIVATE ENTITIES TO**
 2 **OFFER HCFA-SPONSORED HIGH OPTION**
 3 **PLANS.**

4 “(a) PARTNERSHIPS.—

5 “(1) IN GENERAL.—The Director of the Divi-
 6 sion of HCFA-Sponsored Plans of HCFA (in this
 7 section referred to as the ‘Director’) shall contract
 8 with private entities for the provision of outpatient
 9 prescription drug benefits under a HCFA-sponsored
 10 high option plan.

11 “(2) PRIVATE ENTITIES.—The private entities
 12 described in paragraph (1) shall include insurers (in-
 13 cluding issuers of Medicare supplemental policies
 14 under section 1882), pharmaceutical benefit man-
 15 agers, chain pharmacies, groups of independent
 16 pharmacies, and other private entities that the Medi-
 17 care Board determines are appropriate.

18 “(3) AREAS.—The Director may award a con-
 19 tract to a private entity under this section on a
 20 local, regional, or national basis.

21 “(4) DRUG BENEFITS ONLY THROUGH PRIVATE
 22 ENTITIES.—Drug benefits under a HCFA-sponsored
 23 high option plan shall only be offered through a con-
 24 tract with a private entity under this section.

25 “(b) DIRECTOR REQUIRED TO CONTRACT WITH ANY
 26 WILLING QUALIFIED PRIVATE ENTITY.—The Director

1 may not exclude a private entity from receiving a contract
 2 to provide outpatient prescription drug benefits under a
 3 HCFA-sponsored high option plan if—

4 “(1) the private entity meets all of the require-
 5 ments established by the Medicare Board for pro-
 6 viding such benefits; and

7 “(2) the Medicare Board approves the partner-
 8 ship.

9 “(c) PRIVATE ENTITY AT FINANCIAL RISK.—A pri-
 10 vate entity with a contract under this section shall bear
 11 full financial risk for the provision of outpatient prescrip-
 12 tion drug benefits under a HCFA-sponsored high option
 13 plan. The Division of HCFA-Sponsored Plans of HCFA
 14 shall bear no financial risk for the provision of such bene-
 15 fits.

16 **“SEC. 2284. HCFA BUSINESS PLANNING AND ADMINISTRA-**
 17 **TIVE FLEXIBILITY.**

18 “(a) SUBMISSION OF BUSINESS PLAN.—

19 “(1) IN GENERAL.—On January 1 of each year
 20 (but not later than January 1, 2002), the Director
 21 of the Division of HCFA-Sponsored Plans of HCFA
 22 (in this section referred to as the ‘Director’) shall
 23 submit a business plan on the operation of the
 24 HCFA-sponsored standard and high-option plans
 25 to—

1 “(A) both Houses of Congress;

2 “(B) the Director of the Congressional
3 Budget Office;

4 “(C) the Comptroller General of the
5 United States; and

6 “(D) the Chairman of the Medicare Pay-
7 ment Advisory Commission.

8 “(2) BUSINESS PLAN.—The business plan on
9 the operation of the HCFA-sponsored standard and
10 high-option plans described in paragraph (1) shall
11 include—

12 “(A) a comprehensive payment and man-
13 agement plan for all aspects of offering the core
14 benefits under such plans;

15 “(B) information regarding contracts with
16 private entities under section 2283 for the pro-
17 vision of outpatient prescription drug benefits
18 under HCFA-sponsored high option plans;

19 “(C) recommendations for the coordination
20 of, and improvements to, benefits provided
21 under the HCFA-sponsored standard and high-
22 option plans; and

23 “(D) a legislative proposal that implements
24 the business plan.

25 “(b) MAINTAINING INDEPENDENCE.—

1 “(1) EXEMPTION FROM OMB OVERSIGHT.—The
2 Director may directly submit the business plan
3 under subsection (a) to Congress and the individuals
4 described in subparagraphs (B) through (D) of sub-
5 section (a)(1). No officer or agency of the United
6 States may require the Director to submit such plan
7 to any officer or agency of the United States for ap-
8 proval, comments, or review, prior to the submission
9 of the plan to Congress and such individuals.

10 “(2) EXEMPTION FROM APA REQUIREMENTS.—
11 Any action of the Director in preparing or submit-
12 ting the business plan under subsection (a) to Con-
13 gress and the individuals described in subparagraphs
14 (B) through (D) of subsection (a)(1) shall be exempt
15 from the requirements of subchapter 2 of chapter 5
16 of title 5, United States Code (commonly known as
17 the ‘Administrative Procedure Act’).

18 “(c) COMMENTS.—

19 “(1) IN GENERAL.—Not later than 60 days
20 after the date on which the Director submits the
21 business plan under subsection (a) to the individuals
22 described in subparagraphs (B) through (D) of sub-
23 section (a)(1), such individuals shall independently
24 submit comments on such plan to Congress. Such
25 comments should address the impact that the plan

1 would have on costs, providers, and beneficiary ac-
2 cess to care under the Medicare Program.

3 “(2) OPPORTUNITY FOR PUBLIC COMMENT.—

4 The Director shall establish a procedure that allows
5 for public comment on the business plan and shall
6 submit to Congress a summary of such comments
7 not later than the date described in paragraph (1).

8 “(d) CONGRESSIONAL HEARINGS.—Each year that
9 the business plan is submitted to Congress pursuant to
10 subsection (a)(1), the appropriate committees of Congress
11 shall hold hearings on such plan.

12 “(e) FAST-TRACK CONSIDERATION OF BUSINESS
13 PLAN LEGISLATION.—

14 “(1) RULES OF HOUSE OF REPRESENTATIVES
15 AND SENATE.—This subsection is enacted by
16 Congress—

17 “(A) as an exercise of the rulemaking
18 power of the House of Representatives and the
19 Senate, respectively, and is deemed a part of
20 the rules of each House of Congress, but—

21 “(i) is applicable only with respect to
22 the procedure to be followed in that House
23 of Congress in the case of an implementing
24 bill (as defined in paragraph (4)); and

1 “(ii) supersedes other rules only to
 2 the extent that such rules are inconsistent
 3 with this section; and

4 “(B) with full recognition of the constitu-
 5 tional right of either House of Congress to
 6 change the rules (so far as relating to the pro-
 7 cedure of that House of Congress) at any time,
 8 in the same manner and to the same extent as
 9 in the case of any other rule of that House of
 10 Congress.

11 “(2) INTRODUCTION AND REFERRAL.—

12 “(A) INTRODUCTION.—

13 “(i) IN GENERAL.—Subject to sub-
 14 paragraph (B), on the day on which the
 15 Director submits the business plan re-
 16 quired to be submitted on January 1,
 17 2005, pursuant to subsection (a)(1) to the
 18 House of Representatives and the Senate,
 19 the legislative proposal contained in such
 20 plan shall be introduced as a bill (by re-
 21 quest) in the following manner:

22 “(I) HOUSE OF REPRESENTA-
 23 TIVES.—In the House of Representa-
 24 tives, by the Majority Leader, for
 25 himself and the Minority Leader, or

1 by Members of the House of Rep-
2 resentatives designated by the Major-
3 ity Leader and Minority Leader.

4 “(II) SENATE.—In the Senate,
5 by the Majority Leader, for himself
6 and the Minority Leader, or by Mem-
7 bers of the Senate designated by the
8 Majority Leader and Minority Leader.

9 “(ii) SPECIAL RULE.—If either House
10 of Congress is not in session on the day on
11 which the business plan is submitted, the
12 legislative proposal contained in such plan
13 shall be introduced as a bill in that House
14 of Congress, as provided in subparagraph
15 (A), on the first day thereafter on which
16 that House of Congress is in session.

17 “(B) REFERRAL.—Such bills shall be re-
18 ferred by the presiding officers of the respective
19 Houses to the appropriate committee, or, in the
20 case of a bill containing provisions within the
21 jurisdiction of 2 or more committees, jointly to
22 such committees for consideration of those pro-
23 visions within their respective jurisdictions.

24 “(3) CONSIDERATION.—After the legislative
25 proposal has been introduced as a bill and referred

1 under paragraph (2), such implementing bill shall be
2 considered in the same manner as an implementing
3 bill is considered under subsections (d), (e), (f), and
4 (g) of section 151 of the Trade Act of 1974 (19
5 U.S.C. 2191).

6 “(4) IMPLEMENTING BILL DEFINED.—In this
7 section, the term ‘implementing bill’ means only the
8 legislative proposal contained in the business plan
9 required to be submitted on January 1, 2005, by the
10 Director to the House of Representatives and the
11 Senate under subsection (a)(1), and introduced and
12 referred as provided in paragraph (2) as a bill of ei-
13 ther House of Congress.

14 “(5) COUNTING OF DAYS.—For purposes of this
15 section, any period of days referred to in section 151
16 of the Trade Act of 1974 shall be computed by
17 excluding—

18 “(A) the days on which either House of
19 Congress is not in session because of an ad-
20 journment of more than 3 days to a day certain
21 or an adjournment of Congress sine die; and

22 “(B) any Saturday and Sunday, not ex-
23 cluded under subparagraph (A), when either
24 House is not in session.

1 “(f) IMPLEMENTATION OF BUSINESS PLANS SUB-
 2 MITTED AFTER 2007.—Beginning with the business plan
 3 required to be submitted on January 1, 2008, under sub-
 4 section (a)(1), the Director may implement the provisions
 5 of such plan without further legislative action.”.

6 **TITLE II—SPECIAL**
 7 **PROTECTIONS**
 8 **Subtitle A—Protection Package for**
 9 **Certain Areas**

10 **SEC. 201. LIMITATION ON BENEFICIARY OBLIGATIONS IN**
 11 **CERTAIN AREAS.**

12 Section 2227(a) of the Social Security Act, as added
 13 by section 101, is amended—

14 (1) in paragraph (3), by redesignating subpara-
 15 graphs (A) and (B) as clauses (i) and (ii), respec-
 16 tively;

17 (2) by redesignating paragraphs (1) through
 18 (3) as subparagraphs (A) through (C), respectively;

19 (3) by striking “(a) COMPUTATION OF BENE-
 20 FICIARY OBLIGATION.—Subject to subsection (b),”
 21 and inserting the following:

22 “(a) COMPUTATION OF BENEFICIARY OBLIGA-
 23 TION.—

24 “(1) IN GENERAL.—Subject to subsection (b),”;

25 and

1 (4) by adding at the end the following:

2 “(2) LIMITATION ON BENEFICIARY OBLIGA-
3 TIONS IN CERTAIN AREAS.—Notwithstanding para-
4 graph (1), if the only Medicare plans offered in a
5 service area are the HCFA-sponsored plans—

6 “(A) the beneficiary obligation for the
7 HCFA-sponsored standard plan shall not ex-
8 ceed 12 percent of the national average pre-
9 mium; and

10 “(B) the beneficiary obligation for any
11 HCFA-sponsored high option plan shall not ex-
12 ceed the sum of—

13 “(i) 12 percent of the national aver-
14 age premium; and

15 “(ii) the amount by which the bene-
16 ficiary obligation for the HCFA-sponsored
17 high option plan exceeds the beneficiary
18 obligation for the HCFA-sponsored stand-
19 ard plan.”.

20 **SEC. 202. GUARANTEE OF OUTPATIENT PRESCRIPTION**
21 **DRUGS UNDER HCFA-SPONSORED HIGH OP-**
22 **TION PLANS.**

23 Section 2283 of the Social Security Act, as added by
24 section 101, is amended—

1 (1) in subsection (a)(4), by striking “Drug ben-
 2 efits” and inserting “Except as provided in sub-
 3 section (d), drug benefits”; and

4 (2) by adding at the end the following:

5 “(d) PROTECTION FOR AREAS WITH NO CONTRACT
 6 WITH A PRIVATE ENTITY IN EFFECT.—In the case of an
 7 area where no private entity has entered into a contract
 8 with the Director for the provision of outpatient prescrip-
 9 tion drug benefits under a HCFA-sponsored high option
 10 plan, the Medicare Board shall establish an arrangement
 11 through which the Board guarantees to Medicare bene-
 12 ficiaries enrolled in such plan the coverage for outpatient
 13 prescription drugs required under section 2282.”.

14 **Subtitle B—Low-Income Medicare**
 15 **Beneficiary Protection Package**

16 **SEC. 251. MEDICARE PLANS FOR LOW-INCOME MEDICARE**
 17 **BENEFICIARIES.**

18 (a) IN GENERAL.—Title XXII of the Social Security
 19 Act, as added by section 101, is amended—

20 (1) by redesignating section 2229 as 2230; and

21 (2) by inserting after section 2228 the fol-
 22 lowing:

23 **“SEC. 2229. MEDICARE PLANS FOR LOW-INCOME MEDICARE**
 24 **BENEFICIARIES.**

25 “(a) ENROLLMENT IN A MEDICARE PLAN.—

1 “(1) LOW-INCOME MEDICARE BENEFICIARY DE-
 2 FINED.—For purposes of this part, the term ‘low-in-
 3 come Medicare beneficiary’ means a Medicare bene-
 4 ficiary whose income (as determined for purposes of
 5 section 1905(p)) does not exceed 135 percent of the
 6 official poverty line (referred to in paragraph (2)(A)
 7 of such section) applicable to a family of the size in-
 8 volved.

9 “(2) ZERO BENEFICIARY PREMIUM OBLIGATION
 10 FOR THE LOWEST COST HIGH OPTION MEDICARE
 11 PLAN.—A low-income Medicare beneficiary shall
 12 have no obligation to pay any amount for enrollment
 13 in the lowest cost (for such year) high option Medi-
 14 care plan that is available (including on the basis of
 15 capacity to deliver services to enrollees) for the serv-
 16 ice area in which such beneficiary resides.

17 “(3) BENEFICIARY OBLIGATION IN CASE OF EN-
 18 ROLLMENT IN A MEDICARE PLAN THAT IS NOT THE
 19 LOWEST COST HIGH OPTION MEDICARE PLAN.—If a
 20 low-income Medicare beneficiary enrolls in a Medi-
 21 care plan other than the lowest cost high option
 22 Medicare plan available to the beneficiary (including
 23 a standard Medicare plan), the amount of the bene-
 24 ficiary obligation shall be the lesser of—

1 “(A) the amount of the beneficiary obliga-
2 tion computed under section 2227; or

3 “(B) the amount by which—

4 “(i) the amount of the premium ap-
5 proved by the Board under section 2223
6 for the Medicare plan in which the bene-
7 ficiary is enrolled; exceeds

8 “(ii) the amount of the premium ap-
9 proved by the Board under such section for
10 the lowest cost high option Medicare plan
11 available to the beneficiary.

12 “(4) BOARD PAYMENTS TO PLANS.—Payments
13 to Medicare plans in which low-income Medicare
14 beneficiaries are enrolled shall be made in the same
15 manner as payments are made to Medicare plans
16 under section 2226.

17 “(5) COLLECTION OF BENEFICIARY OBLIGA-
18 TION.—The Medicare Board shall collect any bene-
19 ficiary obligation determined under paragraph (3) in
20 the same manner as the Board collects such obliga-
21 tions under section 2228.

22 “(b) ANNUAL ELIGIBILITY AND ENROLLMENT DE-
23 TERMINATION BY STATES.—

24 “(1) IN GENERAL.—The Medicare Board shall
25 establish an arrangement with each State (as de-

1 fined for purposes of title XIX) under which the
 2 State shall—

3 “(A) determine whether a Medicare bene-
 4 ficiary in the State is a low-income Medicare
 5 beneficiary; and

6 “(B) notify the Board of such determina-
 7 tion and of the Medicare plan in which the ben-
 8 eficiary chooses to enroll for such year.

9 “(2) DURATION.—A determination that a Medi-
 10 care beneficiary is a low-income Medicare beneficiary
 11 shall remain valid for a period of 12 months so long
 12 as the beneficiary remains enrolled in a Medicare
 13 plan.

14 “(3) FEDERAL FINANCIAL ASSISTANCE FOR AD-
 15 MINISTRATIVE COSTS.—For provisions relating to
 16 Federal financial assistance for the administrative
 17 costs incurred by a State in conducting the activities
 18 described in paragraph (1) of this section, see sec-
 19 tion 1903(a)(7)(B).

20 “(c) CONTINUATION OF STATE CONTRIBUTION RE-
 21 QUIREMENTS.—With respect to each low-income Medicare
 22 beneficiary enrolled in a Medicare plan for a year, each
 23 State shall pay (to the Medicare Board, Medicare plan,
 24 or a provider, as appropriate) the following:

1 “(1) DUAL ELIGIBLES.—In the case of such a
2 beneficiary who is eligible for medical assistance
3 under title XIX—

4 “(A) the lesser of—

5 “(i) 12 percent of the national aver-
6 age premium determined under section
7 2225(a) for such year; or

8 “(ii) the amount of the beneficiary ob-
9 ligation computed under section 2227 for
10 the HCFA-sponsored standard plan for the
11 service area in which the beneficiary re-
12 sides for such year;

13 “(B) all coinsurance, deductibles, and cost-
14 sharing imposed under the Medicare plan in
15 which the beneficiary is enrolled;

16 “(C) any additional costs incurred by the
17 beneficiary in excess of the stop-loss coverage
18 for the core benefits provided under the Medi-
19 care plan in which the beneficiary is enrolled;
20 and

21 “(D) to the extent consistent with the
22 State plan under title XIX, any additional costs
23 incurred by the beneficiary for outpatient pre-
24 scription drugs in excess of the limit (if any)
25 imposed for coverage of such drugs under the

1 Medicare plan in which the beneficiary is en-
 2 rolled.

3 “(2) QMBS, SLMBS, QI-IS.—

4 “(A) QMBS.—In the case of such a bene-
 5 ficiary who is described in section 1905(p)(1)—

6 “(i) the amount determined under
 7 paragraph (1)(A) of this section for such
 8 beneficiary; and

9 “(ii) all coinsurance, deductibles, and
 10 cost-sharing imposed under the Medicare
 11 plan in which the beneficiary is enrolled
 12 other than with respect to coverage of out-
 13 patient prescription drugs.

14 “(B) SLMBS, QI-IS.—In the case of such
 15 a beneficiary who is described in clause (iii) or
 16 clause (iv)(I) of section 1902(a)(10)(E), the
 17 amount determined under paragraph (1)(A) of
 18 this section for such beneficiary.

19 “(3) FEDERAL FINANCIAL ASSISTANCE FOR
 20 STATE CONTRIBUTIONS.—For payment of the Fed-
 21 eral medical assistance percentage (as defined in sec-
 22 tion 1905(b)) of the payments made by a State
 23 under this subsection, see section 1903(a)(1)(B).

24 “(4) NONAPPLICATION OF OTHER STATE CON-
 25 TRIBUTION REQUIREMENTS UNDER MEDICAID.—In-

1 sofar as this subsection applies to a low-income
2 Medicare beneficiary, notwithstanding any other pro-
3 vision of law—

4 “(A) a State is not required to provide
5 such beneficiary under a State plan under title
6 XIX medical assistance with respect to Medi-
7 care cost-sharing described in section
8 1905(p)(3) that would otherwise be required to
9 be provided under such plan to the beneficiary;
10 and

11 “(B) except as provided in paragraph
12 (1)(B) and (7)(B) of section 1903(a), Federal
13 financial assistance shall not be available under
14 section 1903 with respect to any Medicare cost-
15 sharing provided for such beneficiary.

16 “(5) NO EFFECT ON OTHER FMAP.—Nothing in
17 this section shall be construed as limiting the ability
18 of a State to receive Federal financial assistance
19 under section 1903 for medical assistance (other
20 than Medicare cost-sharing, insofar as the State’s
21 requirement to provide Medicare cost-sharing to a
22 low-income Medicare beneficiary is modified by this
23 section) provided to a low-income Medicare bene-
24 ficiary who is eligible for medical assistance under
25 the State plan under title XIX.”.

1 (b) CONFORMING AMENDMENTS.—

2 (1) FEDERAL FINANCIAL ASSISTANCE.—Section
3 1903(a) of the Social Security Act (42 U.S.C.
4 1396b(a)) is amended—

5 (A) in paragraph (1), by striking “quarter
6 as medical assistance under the State plan;
7 plus” and inserting “quarter—

8 “(A) as medical assistance under the State
9 plan; and

10 “(B) under section 2229(c); plus”; and

11 (B) in paragraph (7)—

12 (i) by striking “of the remainder” and
13 inserting “of—

14 “(A) the remainder”;

15 (ii) by striking the period and insert-
16 ing “; and”

17 (iii) by adding at the end the fol-
18 lowing:

19 “(B) the amounts expended during such
20 quarter to conduct the activities described in
21 section 2229(b)(1).”.

22 (2) STUDY AND REPORT TO CONGRESS RE-
23 GARDING TRANSITION PERIOD.—Section
24 2201(c)(3)(A)(ii) of the Social Security Act, as
25 added by section 101, is amended by inserting

1 “(and, if applicable, under section 2229)” after
 2 “under section 2227”.

3 (3) AMOUNTS IN MEDICARE TRUST FUND.—
 4 Section 2261(b)(3)(B) of such Act, as so added, is
 5 amended by striking “section 2227” and inserting
 6 “sections 2227 and 2229”.

7 **TITLE III—MEDICARE BENE-**
 8 **FICIARY OUTREACH AND**
 9 **EDUCATION**

10 **SEC. 301. MEDICARE CONSUMER COALITIONS.**

11 (a) ESTABLISHMENT OF MEDICARE CONSUMER COA-
 12 LITIONS.—The Medicare Board (as defined in section
 13 2200(d)(4) of the Social Security Act) shall establish
 14 Medicare Consumer Coalitions (as defined in subsection
 15 (b)) to conduct information programs in accordance with
 16 subsection (e) that—

17 (1) prepare comprehensive, accurate, and un-
 18 derstandable information for Medicare beneficiaries
 19 (as defined in section 2200(d)(3) of such Act) on en-
 20 rollment in Medicare plans (as defined in section
 21 2200(c)(1) of such Act); and

22 (2) disseminate such information to Medicare
 23 beneficiaries in a timely fashion.

24 (b) MEDICARE CONSUMER COALITION DEFINED.—In
 25 this section, the term “Medicare Consumer Coalition”

1 means an entity that is a nonprofit organization operated
 2 under the direction of a board of directors that is pri-
 3 marily composed of Medicare beneficiaries.

4 (c) ESTABLISHMENT OF MEDICARE CONSUMER COA-
 5 LITIONS.—The Board shall—

6 (1) develop and disseminate a request for pro-
 7 posals to establish Medicare Consumer Coalitions in
 8 such areas as the Board determines appropriate to
 9 conduct the information programs described in sub-
 10 section (a); and

11 (2) select a proposal to establish a Medicare
 12 Consumer Coalition to conduct the information pro-
 13 grams in each such area, with a preference for broad
 14 participation by organizations with experience in
 15 providing information to Medicare beneficiaries.

16 (d) PAYMENT TO MEDICARE CONSUMER COALI-
 17 TIONS.—The Board shall pay to each Medicare Consumer
 18 Coalition established under subsection (c) an amount
 19 equal to the sum of any costs incurred—

20 (A) in conducting the information pro-
 21 grams under subsection (a); and

22 (B) in the hiring of staff to conduct the in-
 23 formation programs under such subsection.

24 (e) INFORMATION PROGRAMS.—

1 (1) CONTENTS.—The information programs
2 under subsection (a) shall include a comparison
3 among available Medicare plans as follows:

4 (A) BENEFITS.—A comparison of the ben-
5 efits provided under each Medicare plan.

6 (B) QUALITY AND PERFORMANCE.—The
7 quality and performance of each Medicare plan.

8 (C) BENEFICIARY COSTS.—The costs to
9 Medicare beneficiaries enrolled under each
10 Medicare plan.

11 (D) CONSUMER SATISFACTION SURVEYS.—
12 The results of consumer satisfaction surveys re-
13 garding each Medicare plan.

14 (E) ADDITIONAL INFORMATION.—Such ad-
15 ditional information as the Board may pre-
16 scribe.

17 (2) INFORMATION STANDARDS.—The Board
18 shall develop standards to ensure that the informa-
19 tion provided to Medicare beneficiaries under the in-
20 formation programs is complete, accurate, and uni-
21 form.

22 (3) REVIEW OF INFORMATION.—

23 (A) IN GENERAL.—Subject to subpara-
24 graph (B), the Board may prescribe the proce-
25 dures and conditions under which a Medicare

1 Consumer Coalition may disseminate informa-
 2 tion to Medicare beneficiaries to ensure the co-
 3 ordination of Federal, State, and local outreach
 4 efforts to Medicare beneficiaries.

5 (B) DEADLINE.—Any information pro-
 6 posed to be furnished to Medicare beneficiaries
 7 under this section shall be submitted to the
 8 Board not later than 45 days before the date on
 9 which the information is to be disseminated to
 10 such beneficiaries.

11 (4) CONSULTATION.—In order to conduct the
 12 information programs under subsection (a), Medi-
 13 care Consumer Coalitions shall consult with entities
 14 that offer Medicare plans, and public and private
 15 purchasers of health care benefits.

16 (f) MONITORING AND REPORT.—

17 (1) MONITORING.—The Board shall closely
 18 monitor and measure the impact of Medicare Con-
 19 sumer Coalitions on—

20 (A) the premiums of Medicare plans in
 21 such area;

22 (B) the quality of items and services cov-
 23 ered under any such Medicare plan;

1 (C) the access of Medicare beneficiaries to
2 items and services covered under the Medicare
3 plan in such area;

4 (D) the choice of Medicare plans in such
5 area;

6 (E) changes in enrollment in Medicare
7 plans in such area; and

8 (F) such other factors as the Board deter-
9 mines appropriate.

10 (2) REPORT.—Not later than December 31,
11 2003, the Board shall submit to the appropriate
12 committees of Congress a report on the aspects of
13 Medicare Consumer Coalitions monitored under
14 paragraph (1), together with an assessment of the
15 outreach efforts conducted under this section.

16 (g) AUTHORIZATION OF APPROPRIATIONS.—

17 (1) IN GENERAL.—There are authorized to be
18 appropriated to carry out this section such sums as
19 may be necessary.

20 (2) DEPOSIT INTO MEDICARE TRUST FUND.—

21 Sums appropriated under paragraph (1) shall be
22 transferred to the Medicare Trust Fund.

23 (h) EFFECTIVE DATE.—The Board shall establish
24 the Medicare Consumer Coalitions under this section in
25 a timely manner that ensures the information programs

1 conducted by Medicare Consumer Coalitions begin not
2 later than January 1, 2003.

3 **TITLE IV—MISCELLANEOUS**

4 **SEC. 401. CONFORMING AMENDMENTS.**

5 (a) EXECUTIVE SCHEDULE PAY RATES.—Section
6 5316 of title 5, United States Code, is amended by adding
7 at the end the following:

8 “Director, Division of HCFA-Sponsored Plans,
9 Health Care Financing Administration.

10 “Director, Division of Health Programs, Health
11 Care Financing Administration.”.

12 (b) SUBMISSION OF ADDITIONAL CONFORMING
13 AMENDMENTS.—Not later than 6 months after the date
14 of enactment of this Act, the Secretary of Health and
15 Human Services shall submit a legislative proposal to Con-
16 gress containing technical and conforming amendments to
17 reflect the changes made by this Act.

18 **SEC. 402. MEDICARE SUPPLEMENTAL POLICIES.**

19 Notwithstanding section 1882 of the Social Security
20 Act (42 U.S.C. 1395ss), beginning on January 1, 2003,
21 only Medicare beneficiaries enrolled in the HCFA-spon-
22 sored standard plan established under section
23 2282(a)(2)(A) may purchase or renew Medicare supple-
24 mental insurance policies.

1 **SEC. 403. EFFECTIVE DATE.**

2 Unless otherwise specified in this Act, this Act and
3 the amendments made by this Act shall take effect on the
4 date of enactment of this Act.

